FREQUENTLY ASKED QUESTIONS

About the Early Intervention Program

Coding and Reimbursement

Frequently Asked Questions (FAQ) from March 18, 2005

1. How is files management billed?
    - File Management/X0806 is now a client specific service. The code is a per diem; one day equals one unit. The dates of service on the claim must be spanned to match the units on the claim. If you are billing for 7 days/units then the dates of service must equal seven days (ex: 1/1/05 – 1/7/05).

Frequently Asked Questions (FAQ) from March 11, 2005

1. Can one discipline alone bill for a functional assessment when eligibility is known? Or are 2 disciplines still required??
    - Please refer to Question #3 under March 4th.
    - X0243 is an assessment by 2 clinician so providers may not bill using this code for one discipline if eligibility is known
    - For 1 person/discipline to complete an assessment when eligibility is known, providers should bill X0235/69150 with the appropriate time

Frequently Asked Questions (FAQ) from March 4, 2005

1. How many units should be billed for 20 minutes of non-medical case management under code X0241? How many units should be billed for 20 minutes of non-medical case management under the code T1016?
    - The time stated for each unit is a minimum.
    - X0241 should be billed for 1 (30 minute) unit if at least 30 minutes of service are provided.
    - T1016 should be billed for 1 (15 minute) unit if 20 minutes of service are provided.

2. How should a speech therapist, physical therapist or educator that is not the service coordinator bill for XO244 Progress Review/S0316 Follow-up Reassessment. Reimbursement Procedures (5/02) and Operational Standards (9/04) all call for participation when necessary and to bill as their discipline. How can the above be viewed under the EI codes Crosswalk to National Codes (1/05)?
    - A progress review should be billed as a X0244 and 4 units are the total units allowed for this service. The service coordinator can bill X0241.

3. If a child comes to Early Intervention with an outside evaluation determining delay in one area (Motor, Communication), does Early Intervention still need to do an arena assessment or can an educator (or 1 discipline) finish an evaluation in all area's of the child's development?
    - If eligibility is clear (i.e.delay in one area of 2 standard deviations below the mean) by the outside evaluation, than an eligibility evaluation by the EI provider is not necessary, only a functional assessment is needed to develop an appropriate IFSP.

Frequently Asked Questions (FAQ) from February 25, 2005

1. Assistive Tech devices were previously billed on a spread sheet to DOH submitting it with a copy of the invoice. Through EDS are we just billing from the invoice and for how many units? Do we include shipping charges also or just for the device? Do we need to still submit a copy of the invoice? If so, how do we do this?
    - Assistive Technology will continue to be prior approved by DHS. Please continue to forward all requests to Cynthia Holmes. The bill/claim should be sent to EDS with the appropriate number of units and cost for the item approved. DHS is in the process of reviewing the Assistive Technology policy.

2. What should a provider do when they submit to a primary insurance, not covered by the mandate, (examples: self-funded/Citizens or out of state/BCBS of MA), the primary pays the majority of the claim but charges a copay or deductible?
    - The provider should submit to Medicaid for the balance/copay

3. What should a provider do if a RI licensed Insurer (Ex. RI BCBS) charges a copay?
    - The insurer did not process the claim correctly; provider should contact insurer requesting that the claim be amended in their system. The insurer should reprocess the claim and pay the total dollars.

4. What should a provider do if a RI licensed Insurer charges a copay, but when the claim is amended the dollars are completely recouped because the plan is self-funded (Citizens Plans)?
    - The provider should submit the claim to EDS/Medicaid for the total dollars, on paper with COB form attached explaining that the primary insurer not required to cover EI services.

5. Will DHS be providing usage limitations on services? For example, in the past, DOH limited a therapy service like PT to 3 units or 90 minutes. Is there a limitation on case management or supervision use? Any thoughts on this?
    - The usage limitations on services have not changed. For supervision the policy is: The maximum allowed is 30 minutes per child per month and the service must be documented in the child's record.

6. Will DHS be putting out a list to providers of insurance companies licensed in RI? Or, is that something you prefer we check into ourselves with DBR?
    - DHS will not be providing a list of licensed insurance companies. Providers should refer to DBR.

7. On the new crosswalk of codes, some Audiology codes and one vision code (on the National code list) were listed as V codes. In the ICD9 manual, for ex., there is a 9 series code for Hearing Aid evaluation, but the one on the info given out at the last meeting was listed as a V code. Was that an error or was that intentional? What are the implications of billing a V code as opposed to the other? Is the 9 series code reimbursed at a higher rate?
    - The codes on the spreadsheet are not ICD9's. ICD's are diagnosis codes which indicate why a service was needed but not what the service was. The codes on the spreadsheet are either HCPCS or CPT's which are procedure codes, codes describing the service performed.

8. If a child in one EI program transfers to another EI program in the course of the same calendar year, how does the info. transfer to the new provider regarding how close to the insurance cap that family may be?
    - It would be the provider's responsibility to follow-up with the insurance company to find out about how close to the cap the child was. Please refer to the policy/transfer form in the Operational Standards.

9. We have a few individuals on our staff with bachelor degrees in PT or OT, but who are advanced in their field and actually have the rank of Clinical Specialist in their respective areas of training. Part of being a clinical specialist involves supervision. When I reviewed the crosswalk for supervision, I saw that it is divided now into reimbursement for Bachelors, Masters, and Doctoral levels. I just wanted your thoughts on this. Is there any wiggle room here for these particular folks? In other words, can these advanced clinicians bill for supervision at the Masters rate which I equate mostly with a Level II clinician, or do you think we should follow the crosswalk as written?
    - No you can not bill for a masters level clinician unless the individual has a masters. Providers should bill the appropriate level for the individual performing the service.

10. Is there a cap on number of times a case can be supervised in a month? For example, there are many challenging cases that often require multiple supervision sessions, at least initially. Would be interested in your thoughts on this.
    - The January 12th FAQ stated the policy as: The maximum allowed is 30 minutes per child per month and the service must be documented in the child's record.

11. Can a Level I individual participate and get reimbursed for an IFSP meeting?
    - Yes, the minimum criteria for an IFSP meeting (X0245/T1023) is a Level I.

12. Regarding Group services (ex. codes 255, 256, 257), the crosswalk indicates a Level I individual. We also use Level II people for this. If so, is the reimbursement the same?
    - Yes, the reimbursement is for Level I and up

Frequently Asked Questions (FAQ) from February 18, 2005

1. The first one is that on the crosswalk the Max age that is listed on all of the service codes with the exception of X0241 and X0247 is "2". I was informed by our billing department, that we have started receiving denials due to this. Is this a typo? Shouldn't the max age be "3"?
    - The max age for services in our system displays as 2 which allows providers to submit up to the 3rd birthday. We will not pay claims for services beyond the 3rd birthday except in the case of X0241 and X0247.

Frequently Asked Questions (FAQ) from February 11, 2005

1. Can provider be reimbursed for providing service coordination following an area evaluation if child is found not eligible, in order to provide feedback to family about evaluation and offer links to other community resources? Can a parent consultant provide this service?
    - For the time being, if qualified personnel were unable to spend sufficient time with family following the initial evaluation to thoroughly provide explanation of evaluation results and links to community supports, provider may bill 4 units of non-medical case management if child is found not eligible for EI. Parent consultants can provide links to community resources, but should not be providing feedback re: evaluation as this must only be done by qualified personnel.

Frequently Asked Questions (FAQ) from February 4, 2005

1. For file management, can one SRF/billing form be completed for the span of the entire month that the child is enrolled? Would this be all calendar days or only the working days of the month? Is enrollment defined as when the child is deemed eligible (after intake, assessment services and sometimes IFSP) or when the child is referred?
    - Yes file management can be billed for the span of the entire month. Example 1/1/05 – 1/31/05.
    - The units/$amount should reflect the number of days that the service was provided for that child.
    - Enrollment is when a child has a current IFSP.

2. Are Medical Case Management (99361) and Treatment Consultation (99371) only for the use of a physician?
    - Yes

3. What code replaces the 990 prepaid service on the Services Rendered Form?
    - Please continue to use 990 to track parent consultant visits and other non-billable services.

Frequently Asked Questions (FAQ) from January 28, 2005

1. What should a provider do when there is no SS # for a child and EDS has no record of the child in the MMIS?
    - New children are entered through EIMIS. Please hold billing for new children until you submit EIMIS data. If a child has an SS # in the Medicaid system, the SS # for that child should appear within a short time period after your data is submitted. If a child does not have an SS # in the Medicaid system, the process is a bit longer. Your agency will be receiving a report from DHS with a temporary SS # for that child. Once the SS # is received, billing can begin.

2. Can supervision and file management be filed in a separate section of the child's record?
    - Yes

3. Please clarify the start date for the codes.

- National codes must be used in EIMIS and by staff for dates of service beginning 2/1/2005. National codes must be used for billing to the commercial carriers beginning 1/1/2005.
- All (new and old) X Codes are to be used for billing to EDS/Medicaid until further notice.

Frequently Asked Questions (FAQ) from January 21, 2005

1. Where do we send forms that pre- approve conference reimbursement time for staff?
    - Continue to send them to Cynthia Holmes.

2. What are we doing about the 990 code?
    - Please continue to use 990 to track parent consultant visits and other non-billable services.

3. Are we required to make unpaid visits to integrated groups?
    - Technically the state is paying for support to integrated group. Please continue to follow standards set by HEALTH including the tracking of the support visit by using the 990 code. These regulations will be reviewed by DHS in the near future.

4. Will be able to know what our revenue is for each billing period?
    - Providers will have to use their Remittance Advice from Medicaid/EDS and their Explanation of Benefits (EOB) from the commercial carriers to calculate their revenue.

5. Will there be a new report to let us know all billing for the time period now that we are no longer back billing?
    - All billing to Medicaid/EDS will be reported on the Remittance Advice. The Remittance Advice lists the claims in alphabetical order by Recipient Last Name.

6. How should denied claims be processed?
    - Denied claims from EDS should be reprocessed with the corrected information. Karen Murphy can provide assistance with understanding a denial reason. Denials from the commercial carriers should be followed up with the appropriate Carrier.

Frequently Asked Questions (FAQ) from January 13, 2005

1. Will there be a new form to replace the third party access form? And if so, when will it be available?
    - The third party access form is no longer needed. Due to Article 22, parents should no longer be given the option of using their commercial insurance. Insurance information should be collected at intake.

2. Is the supervision and file management going to be billed to the commercial insurances?
    - Yes, <u>all</u> EI services should be billed to commercial insurance. These are child specific and should be documented in the child's record.

3. How is the payment for medical records billed?
    - Documentation for File Management is recorded on a SRF, which is filed in a child's record. The SRF should state the number of days a child received file management for the month.

4. Regarding supervision, if we are now billing through a SRF how will the statistics be effected in terms of marking whether services occurred in a natural environment (and if file management is billed on a SRF how will that also effect the statistics)?
    - Just to be clear, the provider should document supervision on an SRF, however, these services should be billed to EDS on a claim form. With regard to the stats, file Management and supervision will be identified and separated from other services.

5. Will providers be able to use the current SRF for supervision or will be have to use the new SRF which is more geared for the notes on our work with the family?
    - Use the current SRF until the new SRF is in place.

6. Is it possible for EI programs to use the national codes when EDS is ready to accept them, instead of using them now only in EIMIS? The concern is that it creates more work for the providers to have to convert the national codes to the x codes for billing.
    - Unfortunately not. The reason we have required the use of national codes in the EIMIS beginning February 1 is for efficient data collection, reporting and management. We also assumed that this process would make it easier for the direct care providers since national codes must be billed to the commercial carriers for dates of service after 1/1/05.

7. What is the ability for service coordinator I's to do IFSPs and progress reviews?
    - There was an error in the Crosswalk list handed out at the meeting. The IFSP and progress review meetings CAN be done by level 1 staff.

8. A child will only be reimbursed for group services up to 2 hours per week. Is that only for billing for a 254 and 258 services?
    - Changes have been made which affect several codes. Please see new crosswalk for each code. The units are accurate for each service. These services will be reviewed by DHS in the near future.

Frequently Asked Questions (FAQ's) from January 12, 2005

1. File management is now billable at a rate of .33 per child per day. Does this mean we need to enter all children each day?
    - File Management is now a child specific service. Providers should span bill this service for the month for each child. The units would be the # of days the child is enrolled in EI for that month. The total $ billed would be the rate (33 cents per day) times the # of units.

2. How should providers be billing for supervision? What documentation is needed?
    - Providers billing for supervision must meet the criteria stated in the Operational Standards for a clinical supervisor. Supervision is now a child specific service. The maximum allowed is 30 minutes per child per month and the service must be documented in the child's record.

3. What are we doing with families who deny access to their private insurance?
    - The Mandate, Article 22, states that providers can and should access a child's private/commercial insurance. If a family refuses to provide the necessary information but Medicaid is able to determine that the child has private/commercial insurance then that information is shared with the providers through our Recipient Eligibility Verification System (REVS) and the provider should bill the private/commercial insurance accordingly.

4. Is the patient's co-pay and deductibles a part of the $5000 benefit?
    - No, there are no co-pays or deductibles for Early Intervention Services.

5. How should we be billing for the non-direct service (file management and supervision) codes?
    - Non-Direct Services are now child specific services. See item #1 above for documentation about file management. Supervision is reimbursable in 15 minute units at a Bachelor's Level, Master's Level, or Doctoral Level. Please see item #2 above.

6. What is a managed care indicators?
    - For children on Rite care with a claim for dates of service between 10/1/2004 and 12/31/2004, the Managed Care Indicator (MC Ind column on the crosswalk spreadsheet) notifies the provider if the service should be

billed to the Plan the child is enrolled in or to EDS. An 'I' indicates an In Plan service – billable to the Plan and an 'O' indicates an Out of Plan service – billable to Medicaid/EDS. All claims after 1/1/2005 will be billed to the Plans for Rite care children.

7. How do we bill for case conferences?
    - Case Conferences should continue to be billed as they currently are now. With the addition of services and some services becoming child specific, the provider should utilize the most appropriate codes when billing case coordination. For example Treatment Consultation and Clinical Supervision. Further guidance to follow.

8. What are the new codes? Billing rates? Personnel qualified to bill for each service?
    - Please refer to the Codes Crosswalk

9. Integrated group? Will daycare be paid for? Do daycare providers need to be certified for commercial payers?
    - Daycare providers do not need to be certified by the Commercial Insurers. Daycare providers should be licensed by DCYF. DHS is reviewing policy around this service. Further information to follow.

10. Out of State Billing?
    - If unsure about an out of state commercial coverage contact Department of Business Regulations (DBR) to inquiry about the license status of the other coverage. If the out of state coverage is licensed in RI, then bill for the EI services until the benefit is exhausted. If the out of state coverage is not licensed in RI, then bill to the other coverage to receive the denial then bill Medicaid/EDS with the Explanation of Benefits (EOB). For all subsequent claims, utilize the Coordination of Benefits form (See Handout) in lieu of an EOB, to attach to the paper claims submitted to Medicaid/EDS.

11. Adjustments?
    - If the provider has inadvertently billed EDS for the national codes, please submit an adjustment request form asking that the $ be recouped then bill the appropriate local (X code) code.